VERMONT

Office of Vermont Health Access
312 Hurricane Lane, Suite 201
Williston, Vermont 05495

Agency of Human Services

~ GENERAL ~

Prior Authorization Request Form

In order for beneficiaries to receive Medicaid coverage for medications that require prior authorization, the prescriber must telephone or complete and fax this form to MedMetrics Health Partners. Please complete this form in its entirety and sign and date below. Incomplete requests will be returned for additional information.

Submit request via: Fax: 1-866-767-2649 or Phone: 1-800-918-7549

Prescribing physician:

Name:_____
Phone #:_____
Fax #:_____
Address:_____
Contact Person at Office:_____

Beneficiary:

Name:_____
Medicaid ID #:_____
Date of Birth:_____ **Sex:**_____

Will this medication be billed through the: □ pharmacy benefit or □ medical benefit (J-code or other code) ?

Pharmacy **(if known):**_____ **Phone:**_____ **&/or FAX:**_____

1. **Drug Requested:**_____ **Strength, Route & Frequency:**_____ **Length of therapy:**_____
   □ **Brand Name** □ **Generic Equivalent**

2. **Patient's diagnosis for use of this medication:**_____

3. **Previous history of a medical condition, allergies or other pertinent medical information, that necessitates the use of this medication:** _____
   Was patient seen by any other provider for this condition? YES / NO What specialty? _____

4. **Please list preferred medications previously tried and failed for this condition:**

Name of medication	Reason for failure	Date

5. **Please list pertinent laboratory test(s) or procedure(s) if applicable:**

Procedure	Findings	Date

6. **Other Information/ comments:**

Prescriber Signature:_____ **Date of this request:**_____